

**Minutes of Meeting of the 17th AGCA under NRHM
Population Foundation of India, New Delhi
March 15, 2010**

Advisory Group Members present

Dr H Sudarshan
Dr Thelma Narayan
Dr Abhijit Das
Ms Mirai Chatterjee
Dr Narendra Gupta
Shri Alok Mukopadhyay
Dr Shanti Ghosh
Ms Indu Capoor
Dr Abhay Shukla
Dr Saraswati Swain
Shri A R Nanda

Representative from GOI

Mr. Amarjeet Sinha, Joint Secretary

Other invitees

Mr S Ramaseshan, PFI
Ms Sona Sharma, PFI

AGCA Members who could not attend the meeting and were given leave of absence

Dr Dilip Mavalankar
Sh. Harsh Mander
Dr Vijay Aruldas
Dr R S Arole
Dr M Prakasamma
Dr Sharad Iyengar
Prof Ranjit Roy Chaudhury
Mr Gopi Gopalakrishnan

Mr. A R Nanda welcomed the members and special invitees to the 17th AGCA meeting. He shared the agenda of the meeting, which had three discussion points other than the confirmation of the minutes. He said that as Dr. Vijay Aruldas could not attend the meeting, his presentation mentioned in the agenda item will not be taken up. He conveyed that this time eleven members were attending and eight members had requested leave of absence due to their prior commitments and from the GOI, Mr. Amarjeet Sinha would be joining the meeting by 11.30 a.m. Hence the response from GOI on the civil society recommendations for NRHM PIPs would be taken up once he arrives.

Agenda Item No. 1: Confirmation and Action Taken on the minutes of the 16th AGCA Meeting held on December 15, 2009

The minutes of the 16th AGCA meeting were confirmed. A special meeting of the AGCA had been held on February 5, 2010 to anchor civil society inputs in state NRHM PIPs. The meeting included civil society representatives who were involved in the NPCC sub-group meetings in addition to the AGCA members. The AGCA took note of the special meeting after which Dr. Abhijit Das had circulated the collated recommendations. A copy of the recommendations and a record of the proceedings are attached as Annexure I.

Action Points from the 16th AGCA Meeting

As most part of the last meeting was devoted to developing a framework for NGO engagement under NRHM, the action point was:

‘It was suggested that draft guidelines for GIA committee to be edited first by Dr Narendra Gupta and circulated to the sub-group for their feedback. Once these documents are finalized, then a meeting with the Secretary (MoHFW) is to be fixed.’

The above guidelines were drafted by Dr. Narendra Gupta and circulated to the Members for feedback.

Agenda Item No. 2 Community Action for Family Planning/Contraceptive Programme under NRHM – Presentation by Mr. A R Nanda, PFI

Mr. Nanda shared that the Secretary, Health had recently called a meeting to brainstorm on bringing family planning back to the centre stage as there was a national and international view point that family planning had vanished from the radar since ICPD. Mr. Nanda, however clarified that this was not really true. Since ICPD, family planning was contextualized within a broader, rights based, gender sensitive and reproductive health framework. Even before ICPD, within the country there were many concerns from women’s organizations & others on the way things were happening or not happening (the omissions and commissions) in the family planning programme. The ICPD only cemented the concerns and recommendations. However, these perspectives always had pulls and pushes. The Government of India took decision on adopting a Target Free Approach and a comprehensive RH approach. The National Population Policy (NPP – 2000) reinforced the same philosophy.

Even within this new paradigm, elements of ‘quality of care’ were to be the main indicators to be monitored. But with the mindset of people on setting targets (targetitis as it is often referred to), it was found very difficult to adopt a target free approach in its true spirit. Two things happened simultaneously – there were 114 districts where village work plans were developed based on needs of the community and then collated upwards instead of the demographic top down formula. On the other hand, unfortunately many state governments responded into two extremes – either they left it completely i.e. made target free a ‘no-responding’ approach or called it ELA (expected level of achievement) which was basically target. Some who have not reconciled to the

women's health concerns still think that targets should come back. This contradiction continues till date.

Mr. Nanda mentioned that the purpose of his presentation was to deliberate upon the community action required for family planning within health. Some suggestions that have been made in the note circulated to the members are:

- Needs of each village (rural) and ward (urban) must be assessed in terms of unmet needs before a work plan for family planning is made.
- Instead of planning contraceptive requirement based on demographic calculations, plans must be prepared for each village, village plans collated to form the sub-centre plan, sub-centre plans collated for PHC plans and similarly for block and district levels. There have been many instructions issued by the Government for this; however, it is still not being followed. What is required is perhaps that the VHSCs must be empowered to be able to do the planning and monitoring of family planning services as well.
- Quality of care elements relevant to family planning must be widely disseminated and practiced. Making the community aware of the quality of care aspects would empower them to seek/demand quality health care. The community must know and demand quality services.
- The clinical standard guidelines for family planning must be simplified, translated in local language and included as part of the VHSC training. Monitoring of quality of care aspects for family planning could also eventually be taken up under community monitoring.

Mr. Nanda informed the group that these points were also raised in the meeting with the Health Secretary, who acknowledged that they were important aspects. He emphasized the need to ensure that QoC is measured along with CPR. This will be a critical concern, especially when census results come out in 2011 and the demographers raise alarms on population growth once again.

Mr. Nanda requested the members to share their recommendations on two aspects:

1. Should the AGCA take up the issue of community action for family planning or not?
2. If we should, the members are requested to share their thoughts and suggestions on how to go ahead.

The following were the responses/suggestions given by the members:

- Dr. Shanti Ghosh expressed her hope that the horrible time of family planning in the 1970s never comes up again. None of the coercive systems should come back. The only way family planning should be promoted is as a part of the health services. She suggested that the field workers - ANM/ASHA should be trained on the importance of family planning and how to deal with it at individual level.
- Mr Alok Mukhopadhyay mentioned that many situations of lack of quality of care are coming up from UP, MP and Bihar. He felt that the paper was a good beginning and a smaller group could work on it further. The group could come up with concrete

suggestions and include case studies to prove their point. These suggestions could be submitted to the Ministry, which would be timely as the initial discussions for the 12th five year plan have already started.

- Dr. Sudarshan agreed that AGCA should take it up especially in the EAG states. In Karnataka also Community Needs Assessment (CNA) is not being talked about and planners wanted to go back to demographic calculations. There is an urgent need to revive CNA with VHSC at village level. Again, emphasis should be on unmet needs within comprehensive primary health care. Choice should be promoted and the emphasis must be on spacing methods. Andhra Pradesh is also still showing increase in sterilization. Monitoring is possible through Community Based Planning and Monitoring. He was of the opinion that the AGCA should take up the issue first.
- Dr. Abhijit Das commented that there are political and policy dimensions to the issue. He mentioned the London School of Economics Report which links population growth to carbon emissions and strongly recommends the need to debunk that report. He also mentioned that JSK is going back into incentivization by giving private providers rewards which is entirely different from compensation for providing services. He warned that awards can get tricky. He also mentioned that Supreme Court guidelines have come out for service delivery based on reports from the community. Also, quality parameters for the service delivery system exist; however, it was not known whether they are reviewed. Dr. Das also agreed that it could easily be integrated into community action as the parameters already exist.
- Dr. Thelma Narayan was also in agreement and emphasized that a rights based approach must be fundamental. She also shared that there are side effects of family planning methods and there is huge data available on the same. As the programme is driven more from demographic needs and not from the human/ family point of view, there are a lot of social complications also. She felt that in order to ensure QoC, the only way was to strengthen the health systems. The Doctor's and ANMs capacities need to be strengthened, especially for quality of care.
- Dr Narendra Gupta mentioned about an editorial in "Economist" on population decline in Iran and South Korea where-in it was reported that the fertility declined without any special measures. Iran's Total Fertility Rate (TFR) was 7.2 in 1976 which declined to 1.9 in 2001 and Teheran city's to 1.5 without any special effort. He mentioned that even in India, those who have resources rarely go in for terminal methods and still have very low TFR. We are pushing it mainly with the poor and rural community. He felt it was high time to review whether this is the right way for population stabilization.
- Ms. Indu Capoor stressed on three points:
 1. It is possible to improve the quality of services but, it is not possible without appropriate counseling and education. Hence, there is a need to find out the limitations in the programme and at the same time need to improve service delivery and also work towards creating demand for services.
 2. There are a number of young girls who are getting married early and there is need to find out methods more suitable to this group.
 3. Condom is far less promoted than it should be. A mind set change is required to increase condom use.

- Dr Abhijit Das added to the last point that condom has moved from trusted sex to mistrusted sex, mostly because of the repositioning of condom as a means to protect one from HIV and AIDS.
- Dr Abhay Shukla stated that it was essentially a political problem. We need to be clear on whose perspective are we looking at – family (and hence QoC) or demographers. He mentioned that the 'Two child norm' still remains in various forms, for example most benefits in government schemes are only for two children. He further stated that tubectomy was the younger sister and hysterectomy the elder sister and a number of studies exist that prove the relationship. He also emphasized the need to bring in the link to child survival.

Action Point: The discussion concluded with a decision to form a sub-group that would collate evidence and prepare a white paper to be taken forward. The sub-group includes Dr Abhijit Das, as convener, Dr. Thelma Narayan, Dr. Mirai Chatterjee, Dr. H Sudarshan, Dr Saraswati Swain and secretarial support would be provided by PFI (Dr. Almas Ali and Ms. Sona Sharma). It was decided that every meeting of AGCA would have this as an agenda item.

Agenda Item No. 3: GOI Response to AGCA recommendations for state PIPs

Mr. Amarjeet Sinha apprised the group of the following:

- By 31st March the Ministry is trying to ensure that all 35 states and UTs have approved PIPs.
- He sincerely thanked all the members for their participation in the PIP process and for the recommendations provided. He assured the group that each point is part of the recording and will be considered in the PIPs.
- After the pilot on Community Monitoring in nine states, GOI was keen on starting the initiative in more states. This year around 26 states have incorporated CM and the Ministry will also add it in the remaining states.
- The responsibility for the MNGO programme has also been given to Mr. Sinha. He mentioned that in many states the RRCs have not been able to establish a good working relationship with the state government and hence the programme was being reviewed. While there was no intention of disturbing the programme, Mr. Sinha emphasized that they would like to ensure that there is a suitable NGO available at the state level. He mentioned that a Grants in Aid Committee would be set up in each state which would include members of AGCA and GoI for selection of NGOs for various programme. The need was for an institutional partnership with NGOs that goes beyond stand alone activities.
- For community monitoring, it may not be viable to give it only to GIA committee. GOI would continue to provide resources centrally as well, especially in states where it does not take off. The GOI has a commitment to roll out CM across the country.
- Referring to the point made about raising the budget for medicines, he clarified that NRHM can provide for medicines but would not want to replace the state's responsibility for the same. The states have been instructed to put their essential drug

- list & rational drug use policy in place in a month. Based on per capita spending by the state government, NRHM will increase the budget too.
- Mr. Sinha sincerely thanked the civil society representatives who participated in the PIP process, especially for the technical points they made, for example at the north east meeting some of the technical evidence related to the problems of vector control helped the states to clear up their thinking on Malaria control.
 - Draft records of proceedings (RoP) of the NRHM PIPs will be on website by April 1. Each state has accepted monitorable targets – 34 – 35 elements are part of the RoP which will be subject to quarterly review. Mechanisms will be put in place to include designated members of AGCA to be involved in the review and provide feedback. Provision has also been made for field visits.
 - Mr. Sinha informed that the Ministry was looking at the monitoring of NRHM implementation linked with the process of NGO involvement in all aspects. He assured that it would be given further emphasis and a column would be included in the reporting format for the states to review the percentage of funds going through civil society.
 - Finally, he informed that the Minister was very keen that states that have done well are awarded on the World Health Day on the basis of some objective criteria of indicators with regard to performance.
 - While the data from SRS will be available by May-June, it is expected that there would be a decline anywhere between 75 to 55 points in the MMR. There have admittedly been a lot of failings and weaknesses, however, there was no political interference in the way – if we fail we are to blame.
 - PHFI was doing a study on an experiment in Chhattisgarh for rural health practitioners, which has shown positive results. The states are also being asked to include reservations for ASHAs in the ANM nursing school.
 - On the Male health worker problem Mr. Sinha elaborated that it was the responsibility of state government – who did not have the required resources. Hence there are only 60000 male health workers as against the 140000 required. GOI is now developing a proposal for male health workers with specific criteria for local recruitment.
 - The demand for funds under NRHM from states is far more as the utilization has gone up.
 - Mr. Sinha informed that NRHM will continue to be as open to critics, however, the group must support the fact that there is still a need to strengthen the public systems. (as the neo-liberal faction does not accept the value of a public system).

The following were responses/queries from the members to GOI:

- Alok Mukhopadhyay mentioned that the last point is very important. He informed the group that the ‘Asim Das Gupta Committee’ looking at the centre state distribution of resources. They are trying for the introduction of the concept of taxation on merit goods and non-merit goods. Merit goods means essential medicines, basic food for poor people and non-merit means alcohols, tobacco etc. States now have a lot more resources so it is the state’s responsibility to top up their social sector budget. The

second issue is to look at the absorption capacity of states in terms of spending the budget allocated through NRHM.

- Ms Mirai Chhatterjee mentioned that nutrition was one of the key issues discussed in the last AGCA meeting. Referring to Mr. Amarjeet Sinha's point that nutrition is the subject for the Department of Women and Child Development, it was pointed out that there are lots of interventions on nutrition, which can be implemented by the health worker of the Health Department too. However, the Government policy on nutrition is still being debated and it needs to be firmed up.
- Dr Abhay Shukla mentioned that he had circulated a note listing out some health issues. He questioned on the status of guaranteed health services and emphasized that it must be publicly declared – not in a punitive spirit but public needs to know, which is the core of NRHM. The group needs to consider how that can be done. He also suggested that in states where CBM is underway, the NRHM review should be at the state level CBM. On the issue of essential medicines he mentioned that corruption remains a serious problem. Some institutional amendments were absolutely essential. Procurement guidelines are currently given from centre. He suggested that procurement audit should be allowed under CBM.
- Another point raised was regarding the Private sector. Questions asked were – what are we doing to regulate the elephant? Why are we shying away from it? Can NRHM raise the issue of regulating the private sector also.
- Dr. Abhijit Das commented that the update was very heartening and assured that the group was very much in favour of strengthening the public system. He pointed out certain relationships to be focused:
 - The relationship between community and the health system within one framework. We don't have a regulatory mechanism for health and need a common ombudsperson body that looks at public and private sector.
 - NGO-state relationships varied – most states are antagonistic towards NGOs. It is essential for NGOs to move from service delivery to a more active partnership.
 - On Public Private Partnership – Chiranjeevi seems to be a magic wand spreading across states. There is no consideration of local situations.
- Dr. Narendra Gupta commented that there was no reason that public system needs to be critiqued. There is a lot being done by the system which must be acknowledged. He, however, pointed out that the budgetary allocation for health is still far less than the promised 2% of GDP. He queried whether the Ministry had any plans and requested to raise the same to 2%.
- Dr. Thelma Narayan also admitted that NRHM is making a difference. However, to achieve the goal of anti-corruption, she suggested that there should be a public health cadre which is multi-disciplinary and different from clinicians. She also pointed out that the Public health expenses were way below any institutional norm. She suggested that there should be a reasonable, rational norm for the same. She also emphasized the need for measurement of success. Research must be an integral part of any intervention which should also measure determinants of health.
- Dr Swain pointed out that in many states privatization was being promoted by government. Ministers also promote private hospitals and private medical schools. Private hospitals will not go to the remote areas where the services are required the most. Such policies hence need to be reviewed.

- Dr Sudarshan agreed that a lot of good things have happened. But there are still critics. He mentioned that on the issue of good governance – very little was being covered. A good transfer policy to strengthen the public health cadre, needs to be pushed. Strengthening the directorate is also required. He pointed out that people are still spending 80% Out of pocket expenses (OPE). The attitude should be to reduce OPE utilizing the private service providers through public system. Good accreditation system for the private sector should be introduced.

Mr. Amarjeet Sinha, responding to the above, mentioned that all points made by the members were very relevant. He further stated that the process of creating a public health cadre had already begun with states funding the entire cost of a one year programme designed by premier institutions. 130 officers have already completed the programme while this year there were 250 nominations. It was hoped that by 2011-12 there would be a critical mass of officers trained. However, there was a need to push the separate cadre at the state level as those who have been trained are getting frustrated with no cadre.

In response to the query on the status of national health bill he informed that they had sought time with the minister for a presentation on the same. The urban health programme, he mentioned should be ready with the draft for consultation in the next 15 days and is likely to be launched in 3-4 months.

Mr.Nanda thanked Mr. Sinha for sharing all the information and assured that the AGCA would be there to support the NRHM further. He also suggested that GOI could add some members from the North East as it wasn't represented so far in the AGCA. He also pointed out that there were some members who have never attended a meeting. For example, Mr. Harsh Mander has not attended a single meeting. The Ministry could write to him requesting him to attend. Mr. Nanda also suggested that the existing members could recommend names for additional members.

Agenda Item No. 4: Any Other Matter

- **It was suggested that the group should ask the Health Ministry to invite AGCA for all civil society consultations. (A letter should be written to the Ministry for the same)**
- **There must be a clear cut communication from the Centre to the states regarding the involvement of AGCA members/Nodal NGOs in PIP monitoring, with specific names mentioned as was done for the pilot on community monitoring.**
- In Maharashtra, there was a proposed involvement of SHSRC in CBM and they required a guideline from AGCA for the same. The members cautioned against dividing the financial and administrative powers among different organizations and asked Maharashtra to reconsider the same.
- Dr Narendra Gupta once again brought up the issue of money for free treatment. He mentioned that most state governments were not in a position to put in extra money. He felt that AGCA must initiate the process to take it up more strongly as the community was bearing a heavy cost – there was hardly any reduction in OPE in spite

- of NRHM. **It was suggested that Dr. Narendra Gupta should write a note on the same and it would be taken up as an agenda in the next AGCA meeting.**
- Dr Sunil Kaul (The ANT, Assam), Dr Mohammed Shakeel (CHARM, Bihar), Dr Ajay Khare (MP Gyan Vigyan Samiti, MP) were some names suggested. **However, it was decided that those being recommended would first be asked to agree, especially since it involved dedicating their time to the Group.**
 - It was mentioned that the community monitoring pilot had no national report and there was a national dissemination workshop required. **Dr. Abhijit Das informed that there was a draft report which could be circulated to the group for their inputs. The report could be released in a dissemination workshop a day before the next AGCA meeting. Permission would be sought from the Ministry for the national dissemination workshop.**
 - The Ministry also needed to be asked for response to the resource centre proposal. It was felt that the AGCA meetings would be more meaningful if the actionable points are followed up for action by a resource centre.

It was decided that the next AGCA meeting would be held on June 17, 2010 and the proposed date for the national dissemination would be June 16, 2010.

Action Points

Sl. No.	Actionable Points	Action to be taken
1.	It was decided to form a sub-group includes Dr Abhijit Das, as convener, Dr. Thelma Narayan, Dr. Mirai Chatterjee, Dr. H Sudarshan, Dr Saraswati Swain and secretarial support would be provided by PFI (Dr. Almas Ali and Ms. Sona Sharma), would collate evidence and prepare a white paper to be taken forward. It was also decided that every meeting of AGCA would have this as an agenda item.	Background material was forwarded
2.	A letter should be written by the group to the Ministry to invite AGCA members for all civil society consultations.	To be done
3.	There must be a clear cut communication from the Centre to the states regarding the involvement of AGCA members/Nodal NGOs in PIP monitoring, with specific names mentioned as was done for the pilot on community monitoring.	
4.	Dr Narendra Gupta should write a note on the issue of money for free treatment as most of the state governments are not in a position to put extra money for the same and it would be taken up as an agenda in the AGCA meeting	Circulating amongst the members for discussion.
5.	Some of the names such as Dr Sunil Kaul (The ANT, Assam), Dr Mohammed Shakeel (CHARM, Bihar), Dr Ajay Khare (MP Gyan Vigyan Samiti, MP) were suggested for inclusion in the sub-group, However, it was decided that those being recommended would first be asked to agree, especially since it involved dedicating their time to the Group.	
6.	Proposed to hold the National Dissemination on Community Monitoring on June 16, 2010	Held on June 16, 2010 at India International Centre.
7.	The Ministry also needed to be asked for response to the resource centre proposal.	